REPORT TO THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

Functioning Of The Massachusetts System For Reviewing The Use Of Medical Services Finance Under Medicaid B-164031(3)

Social and Rehabilitation Service

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

NOV. 24, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

Dear Mr. Chairman:

This is the third of four reports on our reviews of the functioning of State systems for reviewing the use of medical services financed under Medicaid. Our reviews, which were made pursuant to your request of July 2, 1971, were made in Florida, Maryland, Massachusetts, and Missouri. This report describes the utilization review system in Massachusetts.

As agreed to by your office, copies of this report are being made available to the Secretary of Health, Education, and Welfare. We believe that this report would be of interest to committees and other members of Congress, but we will release it only if you agree or publicly announce its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Wilbur D. Mills
Chairman, Committee on Ways
and Means
House of Representatives

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

COMPTROLLER GENERAL'S REPORT
TO THE COMMITTEE ON
WAYS AND MEANS
HOUSE OF REPRESENTATIVES

FUNCTIONING OF THE
MASSACHUSETTS SYSTEM FOR REVIEWING
THE USE OF MEDICAL SERVICES
FINANCED UNDER MEDICAID
Social and Rehabilitation Service
Department of Health, Education, and
Welfare B-164031(3)

D I G E S T

WHY THE REVIEW WAS MADE

This is the third of four reports by the General Accounting Office (GAO) on methods followed by States in reviewing the use of medical services which are financed under the Medicaid program. The reports were requested by the Chairman, House Committee on Ways and Means.

The Chairman suggested that GAO inquire into such matters as the

--identification and correction of excessive use of medical services,

--results achieved under systems established by States to review uses of Medicaid,

--adequacy of State resources providing for the review systems, and

--extent of assistance given by the Department of Health, Education, and Welfare (HEW) to the States in the development of the systems.

Background

State reviews of medical services under Medicaid are conducted to safeguard against unnecessary medical care and services and to determine that Medicaid payments are reasonable and consistent with efficiency, economy, and quality care.

State reviews of the use of Medicaid services are referred to in this report by the technical term "utilization review systems" but in this digest are called review systems.

This report covers the review system followed in Massachusetts. GAO's reports on the review systems followed in Missouri and Florida were issued March 27, 1972, and June 9, 1972, respectively. Another report will cover the system followed in Maryland.

Medicaid is a grant-in-aid program administered by HEW. The Federal Government shares with the States the cost of providing medical care to persons unable to pay. The Federal share in each State depends upon the per capita income of the State. In Massachusetts the Federal share of Medicaid in 1971 was 50 percent.

In fiscal year 1965, before Medicaid total Federal-State medical assistance expenditures under the federally assisted programs authorized by the Social Security Act amounted to $1.3 billion. Under Medicaid such expenditures increased rapidly and amounted to about $3.5 billion in fiscal year 1968.

Congressional concern over Medicaid costs led to amendments to the Social Security Act in 1967 requiring that each State include a system to review the uses of Medicaid.

In this series of reports, GAO is evaluating:

1. General review controls applicable to all medical services.

2. Specific controls applicable to institutional medical services.

3. Specific controls applicable to noninstitutional medical services.

HEW and Massachusetts officials have not examined and commented on this report formally; however, we have discussed matters in the report with them.

FINDINGS AND CONCLUSIONS

During fiscal year 1971 Massachusetts paid about $308 million for medical benefits furnished to about 233,000 Medicaid recipients. The Federal share was about $154 million. (See pp. 10 and 11.)

The Massachusetts Department of Public Welfare administers the State's Medicaid program, including the review system. (See p. 11.) The department has not developed an effective review system to be applied uniformly throughout the State. Rather it has a fragmented system which depends on the ingenuity of local welfare officials operating without adequate direction from the central office. (See p. 14.)

In addition, most Medicaid claims processing and reviews are performed manually. Because of the large volume of claims--about 14 million received annually--a computerized system is needed to provide adequate controls. (See p. 14.)

The system, however, is producing some positive results. For example, a State official estimated that the use of regional dental consultants to approve or disapprove dental services before the services were provided resulted in savings of $1,726,000 in calendar year 1970. (See p. 34.)

Controls applicable to all Medicaid services

Massachusetts has administratively established per diem rates and fee schedules to limit the amounts paid for medical services. The general laws of the State require the Department of Public Welfare to provide controls to insure that (1) recipients and providers are eligible to participate in the program and (2) providers are neither paid twice for the same care or service nor paid in amounts exceeding fee schedules or other applicable limits.

The Department of Public Welfare has not established a centralized system for claims processing and review to detect improper claims. Instead, reliance has been placed on local and regional offices to provide the required controls. (See p. 15.)

Controls applicable to Medicaid institutional services

The institutional services review requirements of the Social Security amendments of 1967 became effective in April 1968. The State's progress toward meeting these requirements has been slow. (See p. 21.)

Of the 534 hospitals and skilled nursing homes participating in the Massachusetts Medicaid program, review plans had been approved for only 154. State officials stated that primary emphasis in its review efforts had been put on assisting these institutions to develop adequate review plans and estimated

that all the participating institutions would have approved plans by December 31, 1972.

The State also revised its review regulations for institutional care but deferred application of the revised regulations to intermediate care facilities (institutions providing care which is less intensive than skilled nursing care but more intensive than that provided in residential facilities) until 1975. Because intermediate care became a Massachusetts Medicaid service on January 1, 1972, it should be subject to review requirements. (See p. 20.)

Controls applicable to Medicaid noninstitutional services

The Department of Public Welfare was reorganized effective July 1, 1968, to provide for direct State administration of public assistance activities. For the most part, however, the department relies on its local and regional offices to control Medicaid expenditures. Many Medicaid review functions are still performed manually by 155 local welfare offices with technical assistance and supervision from the seven regional offices and the central office. (See pp. 23 and 24.)

The department has not provided the welfare offices with specific instructions on how to review provider claims to detect ineligible participants, duplicate payments, excessive fees, overuse, and noncovered services. Therefore the degree to which the review activities are effective varies widely among the 155 welfare service offices conducting the reviews. (See p. 23.)

The department does not keep records of reviews of claims questioned by the local welfare offices and referred to a regional office for resolution. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in claims were not available to enable management officials to (1) identify providers who repeatedly file unreasonable claims and recipients who repeatedly overuse the program, so that their participation in the program may be restrained or stopped, (2) analyze overuse of medical services for the purpose of identifying general trends and providing a basis for developing methods of avoiding such overuse, and (3) make cost-benefit analyses of review activities. (See p. 25.)

New rules and regulations developed for the Massachusetts Medicaid drug program will, if properly implemented, strengthen review activities for drugs. Overall, however, the department has not established effective review controls for noninstitutional services. The effective administration of the large volume of Medicaid services provided by the State requires a centralized computerized management system. (See p. 39.)

Adequacy of State resources

Because of the manner in which the review function is organized and operated in Massachusetts, it is difficult to judge the adequacy of the aggregate resources applied to this function. The State has recognized the need for more effective controls over all public assistance expenditures, including those for Medicaid, and has developed a plan for an automated payment and control system.

The plan, which is now being implemented, will improve some of the

conditions discussed in this report; however, it will not provide for an effective review system, because it does not provide for (1) computers to identify potential overuse, (2) review and investigation of those questionable cases identified, and (3) correction of overuse. (See pp. 40 to 42.)

Extent of assistance by HEW

The small size of HEW's regional professional staff (five persons to assist six states) has limited the amount of assistance provided the State in developing an adequate review system. (See p. 43.)

In October 1971 HEW provided Massachusetts with a model system providing a broad framework within which the State could develop detailed system specifications to meet requirements peculiar to its own system. A State official said that the HEW model system was excellent and could be adapted to the Massachusetts Medicaid program subject to State administrative and legislative approval. (See pp. 44 and 45.)

GAO believes that HEW's model system offers Massachusetts opportunities for establishing an effective review system and should be studied thoroughly. (See p. 47.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should assist the State and monitor State actions to

--make a thorough study of the HEW model system for the purpose of adopting design features offering opportunity for establishing an effective utilization review system,

--provide for the systematic accumulation of data required by management officials to efficiently administer review systems,

--apply its utilization review regulations to intermediate care facilities,

--provide for central State administration of the Medicaid utilization review system, and

--assist participating hospitals and skilled nursing homes to develop adequate utilization review plans. (See pp. 47 and 48.)

CHAPTER 1

INTRODUCTION

In response to a request dated July 2, 1971 (see app. I), from the Chairman, House Committee on Ways and Means, we reviewed the functioning of the utilization review system under the Medicaid program in Massachusetts. We made our review at State and Federal offices having responsibilities relating to Medicaid utilization reviews. The State offices included the Massachusetts Department of Public Welfare's central office in Boston; three of the department's seven regional offices in Boston, Lawrence, and Worcester; four of the department's welfare service offices in Boston, Methuen, Templeton, and Worcester; and the Department of Public Health in Boston.

As requested by the Committee, we inquired into the

--identification and correction of excessive use of medical services,

--results achieved under the utilization review systems,

--adequacy of State resources for utilization review systems, and

--extent of assistance given by the Department of Health, Education, and Welfare (HEW) to the States in developing the systems.

To obtain information on the first two matters, we evaluated utilization review activities administered (1) by the local, regional, and central offices of the Department of Public Welfare for all medical services and (2) by the Department of Public Health for institutional services. In addition, we reviewed and used information from pertinent reports issued by the HEW Audit Agency and the Department of the State Auditor.

HEW and Massachusetts officials have not formally examined and commented on this report; however, we have discussed the report with them.

This is the third of four GAO reports on methods followed by States in reviewing the use of medical services financed under Medicaid.[1] Another report will cover the system followed in Maryland.

DESCRIPTION OF MEDICAID PROGRAM

The Medicaid program, authorized in July 1965 as title XIX of the Social Security Act, as amended (42 U.S.C. 1396), is a grant-in-aid program under which the Federal Government shares with the States the costs of providing medical care to needy persons. The Federal share ranges from 50 to 83 percent, depending on the per capita income in the States. The Federal share of the Massachusetts Medicaid costs in fiscal year 1971 was 50 percent.

Medicaid, like other public assistance programs, is a Federal-State program operated under State direction within Federal guidelines. Within such guidelines each State decides who will be included in the program, what services they will be entitled to receive, and how the program will be administered.

Services provided to Medicaid recipients vary from State to State. All States must provide certain basic medical services required by law; that is, inpatient and outpatient hospital care, laboratory and X-ray services, skilled nursing care for persons 21 years of age or older, home health services for persons entitled to skilled nursing care, screening and treatment for persons under 21 years of age, and physicians' services. Transportation is required by HEW regulation. Additional services--such as dental care, prescribed drugs, eyeglasses, and care for patients 65 years of

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[1]Report to the Committee on Ways and Means, House of Representatives (B-164031(3), Mar. 27, 1972), entitled "Functioning of the Missouri System for Reviewing the Use of Medical Services Financed Under Medicaid."

Report to the Committee on Ways and Means, House of Representatives (B-164031(3), June 9, 1972), entitled "Functioning of the Florida System for Reviewing the Use of Medical Services Financed Under Medicaid."

age or older in institutions for mental diseases and/or for tuberculosis--may be included if a State chooses.

As of March 1972, 48 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had Medicaid programs. For fiscal year 1971 the States and jurisdictions spent about $5.9 billion for Medicaid programs, of which about $3.2 billion was the Federal share.

ADMINISTRATION OF MEDICAID PROGRAM

Medicaid is administered at the Federal level by the Social and Rehabilitation Service, HEW. Under the act States have the primary responsibility to initiate and administer their Medicaid programs. State plans--which provide the basis for Federal grants to the States for their Medicaid programs--are approved by the 10 Regional Commissioners of the Service.

The Regional Commissioners determine whether State programs adhere to the provisions of the approved State plans and to Federal policies, requirements, and instructions contained in HEW's Handbook of Public Assistance Administration and in program regulations. The Regional Commissioner in the Service's regional office in Boston provides general administrative direction for the Medicaid program in Massachusetts.

The HEW Audit Agency audits Federal and State Medicaid responsibilities. The HEW Audit Agency has made--and is currently making--a number of reviews of State Medicaid programs, including selected aspects of the Massachusetts program.

PERSONS ELIGIBLE FOR MEDICAID

Persons receiving public assistance payments under other titles[1] of the Social Security Act are entitled to Medicaid benefits. Almost all other persons covered by Medicaid are persons whose incomes or other financial resources exceed standards set by the States to qualify for public assistance payments but whose resources are not adequate to pay all the costs of their medical care. Coverage of this latter group is at the option of the States. Persons receiving public assistance payments generally are referred to as categorically needy persons, whereas other eligible persons generally are referred to as medically needy persons.

As of January 1972, 27 States or jurisdictions, including Massachusetts, had Medicaid programs covering both the categorically needy and the medically needy and 25 States or jurisdictions had programs covering only the categorically needy.

Categorically needy persons are not required to make any payments from their own funds for medical expenses covered by State Medicaid programs, whereas medically needy persons usually are required to pay part of their medical expenses. The medical expenses which these persons must pay before Medicaid assistance is provided are referred to in this report as the recipients' share of cost. Each recipient's share of cost is computed by deducting what the State has established as necessary for basic living expenses from a person's income or other resources. The remainder (recipient's share of cost) is the amount of medical cost that must be incurred by the recipient before Medicaid will pay.

REQUIREMENTS FOR UTILIZATION REVIEW

In fiscal year 1965, before Medicaid began, total Federal-State medical assistance expenditures under the

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[1] Title I, old-age assistance; title IV, aid to families with dependent children; title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, optional combined plan for titles I, X, and XIV.

federally assisted programs authorized by the Social Security Act amounted to $1.3 billion. Under Medicaid such expenditures increased rapidly and, in fiscal year 1968, amounted to about $3.5 billion.

Congressional concern over rapidly rising Medicaid costs led to legislation in 1967. As a result, an amendment to the Social Security Act required, effective April 1, 1968, that each State Medicaid plan provide methods and procedures (utilization review systems) to safeguard against unnecessary use of medical care and services and to insure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality care.

HEW implementation

To implement this requirement, the Service issued an interim regulation on July 17, 1968, which, after minor modification, was issued as a program regulation on March 4, 1969. The regulation specifies that each State plan must provide for a utilization review for each type of service rendered under the State's Medicaid program. The regulation also requires that the responsibility for making utilization reviews be placed in the medical assistance unit of the State agency responsible for administering the program. The regulation permits delegation of responsibility for utilization review activities for Medicaid inpatient hospital and nursing home services to the agency which monitors such activities under title XVIII of the act (Medicare).

Because there are 52 widely differing medical assistance programs under Medicaid, the language of the regulation is quite broad and permits the States considerable latitude in their approach to utilization review.

The regulation does not specify the manner in which utilization reviews are to be made or establish minimum requirements for utilization review plans.

In April 1969 the Service sent draft guidelines for utilization reviews to its regions for comment. The draft guidelines stated that institutional services should be reviewed for such things as necessity of admission and duration of stay and that noninstitutional services should be

subject to surveillance to see that services rendered are based on actual need and that frequency of care and service is appropriate to that need. The draft guidelines stated also that utilization reviews should include (1) methods of reviewing the need for medical services before the services are provided and (2) reviews to determine the propriety of individual claims and to accumulate, analyze, and evaluate claims data to identify patterns and trends of normal and abnormal use of services.

On December 21, 1971, the Service issued to States its first guidelines for implementing the March 1969 utilization review program regulation. These guidelines contain information regarding State responsibility and administrative criteria for preauthorization of selected types of medical care and services.

MASSACHUSETTS MEDICAID PROGRAM

Massachusetts started its Medicaid program in September 1966. The program provides medical services to both the categorically and medically needy. The program, in addition to paying for the basic services described on page 6, pays for

--prescribed drugs;

--dental services;

--mental and tuberculosis hospital care for recipients 65 and older; and

--special services, such as physical therapy, diagnostic services, podiatry, and payment of premiums, deductibles, and coinsurance for Medicare.

During fiscal year 1971 the State paid about $304.5 million for medical services provided to 233,208 Medicaid recipients. In Massachusetts the State Commission for the Blind administers the Medicaid program for the blind. We did not review this aspect of the program because of the relatively small expenditures ($3.5 million, or about 1 percent of the total) made during fiscal year 1971. Additional data on Massachusetts Medicaid expenditures in fiscal year 1971 follows.

	Fiscal year 1971	
	Providers	Dollars (000 omitted)
Medicaid services:		
Institutional:		
Inpatient hospitals	185	$111,987
Skilled nursing homes	349	97,064
Outpatient hospitals	148	13,686
Public medical institutions	14	5,796
Noninstitutional:		
Prescribed drugs	825[a]	26,160
Physicians	6,132[a]	21,701
Dental care	(b)	17,209
Other medical services	(b)	14,391
Total		$307,994[c]

[a]Estimated by State officials.

[b]Data was not readily available.

[c]Includes $3.5 million of payments by the Commission for the Blind.

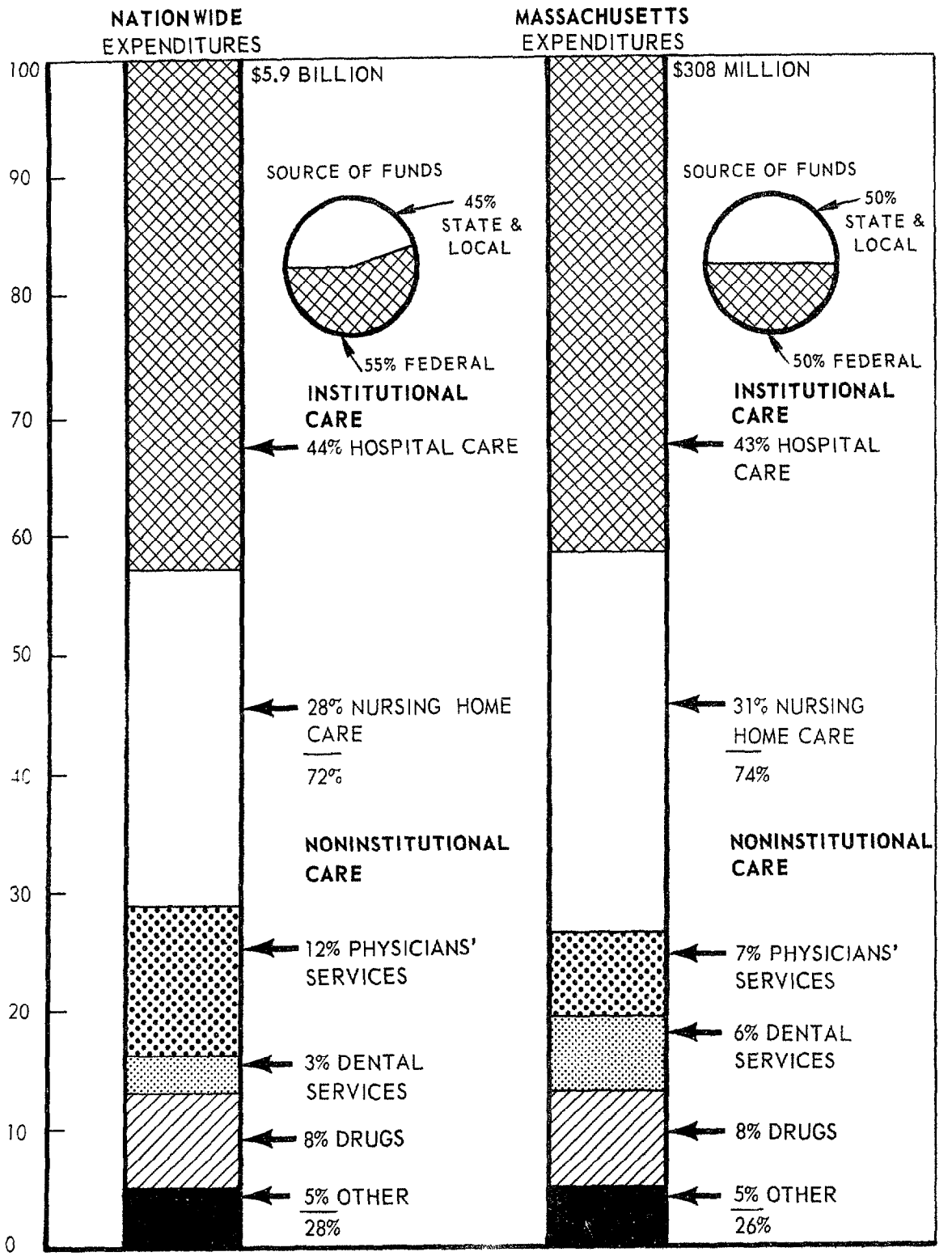
A comparison of the fiscal year 1971 Medicaid expenditures nationwide and in Massachusetts follows.

Administration of Massachusetts Medicaid program

The Department of Public Welfare is the State agency which administers the Medicaid program, including utilization reviews.

Through June 30, 1968, about 250 welfare offices of individual towns and cities administered the program, and the department provided overall supervision through its seven regional offices. This system did not produce the uniformity of administration and information systems necessary for effective utilization review. To provide for direct State administration of public assistance activities, the department was reorganized effective July 1, 1968.

WHERE THE MEDICAID MONEY GOES
NATIONWIDE AND IN MASSACHUSETTS
FISCAL YEAR 1971



Under the reorganization the department was to assume complete financial and administrative responsibilities for the public assistance programs in Massachusetts. The department consolidated the 250 welfare offices into 155 such offices and established 35 finance units throughout the State to serve as payment centers for the 155 welfare offices.

Medicaid activities, including reviews on claims processing and utilization, were to be conducted at local offices with technical assistance and supervision from seven regional offices under the direction of the department's central office. The department was to establish data processing and collection procedures which would provide the statistical data necessary for effective utilization review.

The Massachusetts State plan for medical assistance provides that the plan be in operation, through a State-administered system with offices conveniently located throughout the State, in accordance with equitable standards for assistance and administration that are mandatory throughout the State. The Department of Public Welfare is to insure that the plan is continually in operation throughout the State

--by developing methods for informing staff of State policies, standards, procedures, and instructions;

--by instituting a regular planned examination and evaluation of operations in all offices by assigned State staff, including regular visits by such staff; and

--through reports, controls, or other methods.

The plan requires the department to provide comprehensive medical and remedial care and services to all eligible persons.

Effective July 1, 1970, the Department of Public Welfare placed with the Department of Public Health's Division of Medical Care the responsibility to monitor the utilization review plans of hospitals, extended care facilities, and skilled nursing homes under Medicaid. However, a formal agreement between the two departments had not been entered into as of December 1971.

CHAPTER 2

MASSACHUSETTS MEDICAID UTILIZATION REVIEW SYSTEM

Massachusetts has not developed an effective review system to be applied uniformly throughout the State. Rather it has a fragmented system--depending upon the ingenuity of local welfare officials--operating without adequate direction from the central office of the Department of Public Welfare. In addition, most Medicaid claims processing and utilization reviews are performed manually. Because of the large volume of claims--about 14 million received annually--a computerized system is needed to provide adequate controls.

Effective utilization review of the large volume of Medicaid services provided by the State requires a centralized, uniform system which provides for:

1. A written utilization review plan, which must be State-wide in application and cover all items of care and service included in the State's Medicaid plan.

2. A description of how the State proposes to conduct reviews, which services are to be reviewed after care has been received, which are to be reviewed concurrently, which are to be reviewed before care is received, which are to be reviewed before payment and which after payment, and which are to be reviewed on a sample basis.

3. The use of computer equipment to summarize claims data, to develop participant histories of services provided or received, and to screen and identify participants deviating by specified margins from prescribed parameters, or norms of performance.

4. The review and investigation of deviants to determine whether medical care or services are appropriate or whether overuse has occurred.

5. Appropriate corrective measures in cases involving overuse.

Generally Massachusetts has not adequately developed these basic elements of an effective utilization review system.

The Department of Public Health conducts utilization reviews applicable to institutional services (see ch. 3), which accounted for about 74 percent of the State's Medicaid expenditures in fiscal year 1971. The Department of Public Welfare has, however, retained responsibility for processing claims for institutional Medicaid services.

Utilization review activities applicable to noninstitutional services (see ch. 4) are conducted under the direction of the 155 local welfare offices, with technical assistance and supervision from the seven regional offices and from the central office in Boston.

A discussion of the lack of utilization review procedures providing for general controls applicable to all Medicaid services follows.

NEED FOR GENERAL CONTROLS APPLICABLE TO ALL SERVICES

Massachusetts has administratively established per diem rates and fee schedules to limit the amounts paid for medical services. The general laws of the State require the Department of Public Welfare to provide controls to insure that (1) recipients and providers are eligible to participate in the program and (2) providers are neither paid twice for the same care or service nor paid in amounts exceeding fee schedules or other applicable limits.

The department has not established a centralized system for claims processing and utilization review to direct improper claims but has relied on local and regional offices to provide the required controls. (See ch. 4.)

CHAPTER 3

UTILIZATION REVIEW OF INSTITUTIONAL SERVICES

Of the $308 million paid by Massachusetts for Medicaid services in fiscal year 1971, about $228.5 million, or 74 percent, was for institutional services. About $131.5 million was spent for hospital services, and about $97 million was spent for skilled nursing home services. Hospitals and nursing homes are paid on the basis of per diem rates established by the Massachusetts Rate Setting Commission after reviewing cost reports of individual facilities.

Under the State plan the Department of Public Health monitors utilization review under both the Medicare and Medicaid programs. The department has assigned 25 employees to make visits to hospitals, extended care facilities, and skilled nursing homes to determine whether

--they meet State and Federal requirements for participating in Medicare and Medicaid,

--utilization review plans are adequate and are being properly implemented, and

--deficiencies noted have been corrected.

CONTROLS OVER INPATIENT HOSPITAL CARE

Hospitals participating in the Massachusetts Medicaid program include, in addition to general hospitals, tuberculosis and mental hospitals and public medical institutions (municipally operated medical institutions providing care for patients with chronic diseases). They must meet the utilization review requirements prescribed for Medicare. Medicare requires each hospital to develop a utilization review plan which must provide for review of (1) admissions, duration of stays, and professional services furnished and (2) each case of extended stay. Such reviews are to be made by a committee of at least two physicians.

In each case of extended stay, the hospital is to specify the number of continuous days of hospital stay after which a review is to be made. The hospital may specify a

different number of days for different diagnoses. The purpose of this requirement is to insure a prompt examination of the course of treatment and continuing need for hospital services of each patient involved. This review is designed to protect against program funds being used to pay bills for medically unnecessary hospital services.

A Department of Public Health official informed us that the department's utilization reviews had primarily emphasized assisting hospitals to develop adequate utilization review plans. For example, from January through March 1971 the department reviewed the utilization review plans of 54 hospitals. The plans for 39 hospitals were determined adequate, principally as a result of revisions or corrections of deficiencies in the plans cited previously by the Department of Public Health. Letters were written to the other 15 hospitals describing deficiencies necessitating revision of the plans.

Of the 185 hospitals participating in the Massachusetts Medicaid program in fiscal year 1971, 140, or 76 percent, had utilization review plans which had been approved by the Department of Public Health; nine hospitals, or 5 percent, had submitted utilization review plans which were being reviewed; and 36 hospitals, or 19 percent, had not submitted plans.

A Department of Public Health official stated that the department would continue to assist those hospitals which had not developed adequate utilization review plans. He estimated that all hospitals would have approved plans by December 31, 1972.

CONTROLS OVER SKILLED NURSING HOMES

Skilled nursing homes participating in the Massachusetts Medicaid program must meet the utilization review requirements prescribed for Medicare. Medicare requires each extended care facility to develop a utilization review plan which must provide for review of (1) admissions, duration of stays, and professional services furnished and (2) each case of extended stay. Such reviews are to be made by a committee of at least two physicians.

Under the State's medical care plan, each recipient's continued need for nursing home care must be evaluated at least every 6 months by a medical examination and a review by a social worker.

A department official informed us that the department's utilization reviews had primarily emphasized assisting the extended care facilities to develop utilization review plans adequate for Medicaid as well as for Medicare. For example, from January through March 1971 the department reviewed the utilization review plans for 24 extended care facilities. The plans for 14 facilities were determined adequate, principally as a result of revisions or corrections of deficiencies cited previously by the department. Letters were written to the other 10 facilities describing deficiencies necessitating revision of the plans.

Of the 349 skilled nursing homes participating in the Massachusetts Medicaid program, 97 are also classified as extended care facilities under Medicare. Although these 97 facilities had utilization review plans for Medicare, as of November 1971, only 14 of them had approved plans for Medicaid.

To assist skilled nursing homes in developing adequate utilization review plans, the department developed a model plan in November 1971 and sent it to all skilled nursing homes. A department official estimated that all participating extended care facilities and skilled nursing homes would have approved plans by December 31, 1972.

In May 1969 the department made a study of patients in nursing homes throughout the State. The major aims of the study were to

--obtain detailed information regarding patients and their needs for care,

--assess the appropriateness of State rules and regulations for licensing nursing homes, and

--develop histories of nursing home use that would be helpful for planning purposes.

A survey form was filled out on every patient in every nursing home in the State. A summary of the information obtained showed that 63 percent of 31,349 patients in licensed nursing homes did not need the extent and range of services required by State regulations for licensure as a nursing home. The summary showed that 14 percent of the patients did not require institutional care; 26 percent could have been cared for in rest homes without nursing services; 23 percent needed only limited or periodic nursing care; and only 37 percent needed the skilled nursing services required by State regulations.

Further study by the Department of Public Health showed that neither services nor costs were consistent with the patients' needs. Some facilities caring for patients who needed only limited nursing services had a higher per diem rate than some facilities caring for patients requiring a high level of skilled nursing care.

To correct the deficiencies revealed by its study, the department completely revised its rules and regulations for long-term-care facilities. The new rules and regulations--issued January 12, 1971--which became effective on January 1, 1972, provide for four levels of care based on the varying levels of specialization and patient care among long-term-care facilities.

Level I

Intensive nursing and rehabilitative care facility--This level provides continuous skilled nursing care and an organized program of restorative services in addition to basic minimum services. Level I requirements are similar to the Federal requirements for extended care facilities under Medicare.

Level II

Skilled nursing care facilities--This level provides continuous skilled nursing care and restorative and other therapeutic services in addition to basic minimum services. Level II requirements are similar to the Federal standards for skilled nursing homes under Medicare.

Level III

Supportive nursing care facilities--This level provides routine nursing services and periodic availability of skilled nursing, restorative, and other therapeutic services as indicated by patients' needs in addition to basic minimum services. Level III requirements are a combination of State licensure regulations and Federal standards for intermediate care facilities.[1] These facilities are institutions providing care which is less intensive than skilled nursing care but which is more intensive than that provided in residential facilities.

Level IV

Resident care facilities--This level provides protective supervision in addition to basic minimum services. Level IV requirements are an upgraded version of the State's prior rest home regulations.

The Department of Public Health estimated that, under the new regulations, some personnel costs would be higher but, because of savings resulting from more appropriate classification of patients as to the level of care needed, overall costs would be about the same.

The revised regulations contain utilization review provisions which appear to meet the Federal Medicaid requirements with one exception--applicability of the utilization review requirements to intermediate care facilities is deferred until January 1, 1975. Because intermediate care became a Massachusetts Medicaid service on January 1, 1972, it should be subject to utilization review requirements.

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[1]Public Law 92-223, approved December 28, 1971, provides that effective January 1, 1972, care provided in intermediate care facilities would be included under Medicaid--as an optional service. Such care was previously financed under the various cash assistance programs. Massachusetts has adopted intermediate care as part of Medicaid.

Section 1902(a)(26) of the Social Security Act, as amended, requires that State plans, effective July 1, 1969, provide for a regular program of medical review and evaluation of skilled nursing home care. The Department of Public Health's revised rules and regulations for long-term-care facilities--effective 2-1/2 years later--provide for such a program.

HEW Audit Agency reviews in Massachusetts nursing homes

In June and July 1971 the HEW Audit Agency reported to the Massachusetts Department of Public Welfare that 59 nursing homes had been overpaid about $915,000 because welfare service offices either used an incorrect per diem rate or failed to make retroactive adjustments required by decreases in per diem rates. The overpayments occurred because the welfare service offices had not been keeping their records current to show the latest approved per diem rate.

In an April 1972 report on its review of pharmaceutical services provided under the Massachusetts Medicaid program, the HEW Audit Agency pointed out that recipients in nursing homes were not receiving drugs in economical quantities. Prescriptions were being refilled from two to 13 times a month. Each time a prescription is refilled, it requires a separate billing to the welfare service office and, for certain drugs, an additional payment of $1.80 must be made to the pharmacist as a dispensing fee.

In October 1971--during our fieldwork--we noted that the department had developed, and was in the process of obtaining approval of, revised regulations for drugs and medical supplies. These revised regulations provided that certain drugs, generally prescribed for chronic conditions, must be dispensed in 3-month quantities. The revised regulations became effective February 1, 1972.

EVALUATION OF CONTROLS OVER INSTITUTIONAL SERVICES

The institutional services review requirements of the Social Security amendments of 1967 became effective in April 1968. The State's progress toward meeting these requirements has been slow. Of the 534 hospitals and skilled

nursing homes participating in the Massachusetts Medicaid program, review plans had been approved for only 154. State officials stated that its reviews had primarily emphasized assisting these institutions to develop adequate review plans and estimated that all the participating institutions would have approved plans by December 31, 1972.

The State also revised its regulations for institutional care but deferred application of the revised regulations to intermediate care facilities until 1975. Because intermediate care became a Massachusetts Medicaid service on January 1, 1972, it should be subject to the State's utilization review requirements.

CHAPTER 4

UTILIZATION REVIEW OF NONINSTITUTIONAL SERVICES

The Department of Public Welfare provides a broad program of noninstitutional medical services for Medicaid recipients. Payments for prescribed drugs, physicians' services, and dental care--the principal noninstitutional services--amounted to about $65 million, or 21 percent, of the total Massachusetts Medicaid expenditures for fiscal year 1971. The department has not, however, established an adequate process of utilization review for evaluating the quantity and quality of these services.

To provide for direct State administration of public assistance activities, the Department of Public Welfare was reorganized effective July 1, 1968. (See pp. 11 and 13.) For the most part, however, the department still relies on its local and regional offices to control Medicaid expenditures. Many utilization reviews are still done manually by the local welfare offices.

The Department of Public Welfare has established fee schedules covering most medical services authorized by the program. Welfare offices are required to review claims for conformance with the fee schedules. Claims for medical care for which a fee has not been established--for example, dental surgery, allergy evaluations, and treatment of foot fractures--must be submitted to a regional office so that an appropriate fee may be determined by a regional medical advisor.

For some medical care--for example, orthodontic X-rays and the provision of orthopedic shoes, artificial limbs, and hearing aids--welfare offices must obtain approval from a regional office medical advisor before the care is provided.

Written procedures for processing Medicaid bills are part of the Massachusetts Public Assistance Policy Manual, which was issued to all welfare offices. The procedures are general, however, and do not specify how claims are to be reviewed to detect ineligible participants, duplicate payments, excessive fees, overuse, or noncovered services. The department has not provided its regional and local offices

with parameters or instructions for use in evaluating the extent of medical care furnished by providers.

Because the Department of Public Welfare has not established a centralized system for claims processing and utilization review, improper claims can go undetected. For example, an established State-wide fee schedule allows a physical therapist an $8 fee for the first patient treated and $6 for each additional patient treated during the same visit to a nursing home. We found that one physical therapist, in a claim submitted to one welfare office, charged $6 for additional patients treated in a nursing home on the same day. The same physical therapist, however, submitted a claim to another welfare office claiming an $8 fee for treating an additional patient in the same nursing home on the same day. Although the amounts involved are small, the example does show how overcharges can escape detection. Also, because claims are processed by different welfare offices, the potential for duplicate payments exists.

With continually increasing numbers of Medicaid recipients, the lack of definitive procedures for handling claims, has added to the problems encountered by the local welfare offices in establishing adequate utilization review systems.

The local welfare service offices receive technical assistance and supervision from the seven regional offices and from the central office in Boston. If, during claims processing, the local offices identify claims involving possible overuse but cannot determine if overuse exists, the claims are sent to the medical assistance units of the regional offices for resolution. Claims which cannot be resolved by the regional offices are sent to the central office for resolution.

To evaluate the utilization review activities, we made reviews at four local welfare offices in Boston, Methuen, Templeton, and Worcester; three regional offices in Boston, Lawrence, and Worcester; and the central office in Boston. Of the $79.5 million spent for noninstitutional services under the Massachusetts Medicaid program in fiscal year 1971, the four welfare offices that we visited spent $18.7 million, or about 24 percent.

Records were not maintained at the local, regional, or central office levels of claim reviews initiated at the local level. Therefore, statistics on claims reviewed and approved or disapproved and amounts of reductions in the claims were not available.

Such statistics would enable management officials to (1) identify providers who repeatedly file unreasonable claims and recipients who repeatedly overuse the program, so that their participation in the program may be restrained or stopped, (2) analyze overuse of medical services to identify general trends and to provide a basis for developing methods of avoiding overuse, and (3) make cost-benefit analyses of utilization reviews.

WELFARE OFFICES

Each of the four local welfare offices uses different criteria to determine which Medicaid claims should be evaluated for possible overuse of medical care or services. For example, the Methuen office refers claims to the regional office for evaluation of possible overuse if more than two physicians' visits per recipient in a month are noted; the Worcester office uses four visits as its criterion. The Templeton office refers claims to the regional office if recipients have "unusual numbers" of visits in successive months; the Boston office has no established criterion. The use of different criteria appears to have been caused by the lack of specific instructions from the Department of Public Welfare. These instructions state:

> "Whenever it appears that an unusual number of visits have been made by a physician in one month, a medical report should be obtained from the physician and the matter referred for evaluation to the Regional Office."

Other examples of differences in utilization review procedures at the four welfare offices follow.

--Only the Templeton office analyzed prescriptions for possible overuse.

--Only the Templeton office identified, by tooth number, dental work performed so that subsequent dental bills be analyzed for possible overuse or duplicate billing.

--The Boston office did not check for duplicate payments and the Worcester office's check for duplicate payments was not adequate.

--The Boston office did not determine recipient eligibility.

--The Boston office did not check all Medicaid bills for conformance with the department's fee schedule.

--Boston and Worcester did not maintain recipient or provider profiles (histories of medical services received or provided).

The results of our reviews at the four welfare offices are described in the following sections.

Boston welfare office

At the Boston welfare office, 18 claims examiners process about 160,000 claims manually each month. Each examiner reviews claims from all types of providers. The Boston welfare office has not developed any parameters--such as a limit on the number of physician visits--for use in identifying overuse but relies on the individual judgment of the various claims examiners.

Claims that are questioned by the claims examiners are referred to the supervisor for disposition. If the supervisor is unable to determine whether the claims are proper, they are referred to the medical assistance unit of the Boston regional office. The Boston welfare office does not maintain records of reviews of claims referred to the supervisor by claims examiners or by the supervisor to the regional office. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions were not available.

The Boston welfare office has not established any methods of determining whether (1) the recipient of the medical services is eligible, (2) the claim for the service has been previously paid, or (3) the provided services were medically necessary. Recipient and provider profiles are not maintained for use in relating a questionable claim to a provider's practice or to a recipient's medical history.

Only bills received from physicians and dentists and a sampling of laboratory bills are compared with established fee schedules. Boston welfare officials advised us that additional utilization controls had not been applied because of the large number of claims processed. Further, only since August 1971 have medically needy recipients' shares of costs been checked to insure that the recipients' shares have been paid before Medicaid bills are paid on their behalf. In a July 28, 1971, report to the Congress,[1] we pointed out that Massachusetts did not have a system, other than one for nursing home care, to insure that the recipients' share of cost was met before it paid claims for medical services. As a result, claims paid by Medicaid in Boston during the 7-month period ended October 1969, which should have been paid by the recipients, may have amounted to $61,500.

The Boston welfare office has not, in our opinion, established an effective utilization review system for Medicaid. We believe that, because of the large volume of Medicaid claims, the office needs a system for computerized claims processing and payment, coupled with effective utilization review, for adequate program evaluation and management. Until such a system is made available, however, the Boston welfare office could obtain some of the benefits of utilization review by

--keeping records on the results obtained at the different levels of utilization review;

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[1]Report entitled "Ineffective Controls Over Program Requirements Relating to Medically Needy Persons Covered by Medicaid" (B-164031(3)).

--establishing norms of service to identify possible overuse; and

--performing utilization review on the basis of statistically significant samples of recipients' and providers' cases, giving particular attention to pertinent data, such as the number of visits to a physician; the number, kind, and frequency of prescriptions; and the relationship of tests or medications to diagnoses.

Worcester welfare office

At the Worcester welfare office about 20,000 claims are processed manually each month by 27 full-time and 10 part-time examiners. For the most part, each examiner reviews claims for only one type of provider. Utilization review consists of

--verifying recipients' eligibility by checking with a master file of eligible recipients;

--comparing charges with fee schedules;

--checking the monthly payment summary to see if any claim appears more than once on the summary (claims are not checked, however, to see if a claim duplicates one paid in a prior month);

--checking the number of physician visits per recipient (claims for more than four visits per recipient in a month are referred to the Worcester regional office for evaluation of possible overuse);

--determining that recipients' shares of cost have been met before Medicaid bills are paid on their behalf; and

--comparing claims with the providers' profiles to identify possible overuse of medical care or services.

The Worcester welfare office does not maintain recipient profiles to relate a questionable claim to a recipient's

medical history and does not maintain records of its reviews or of questionable claims referred to the regional office for resolution. The office has not developed any parameters--except for a limit on the number of physician visits--for identifying possible overuse nor established a method of determining whether the provided services were medically necessary.

Without established parameters, or norms of service, the claims examiners use their individual judgment in identifying possible overuse. For example, one clerk noted that a dentist was submitting claims for pulp cappings for children. She questioned this practice and referred a number of this dentist's claims to the regional office for evaluation of possible overuse. A dental consultant at the regional office determined that the provider was overusing pulp cappings and disallowed claims totaling about $3,000.

The Worcester welfare office has not established an effective utilization review system for Medicaid. Although the practice of assigning only one type of provider claim to claims examiners enables them to develop some degree of expertise in reviewing claims, they have not been provided with the guidance necessary to do an effective job. Also the volume of Medicaid claims received by the office is too large for effective reviews of manual processing and of use. Until an automated sysyem becomes available, however, the office should at least establish parameters to identify possible overuse, provide for a method to evaluate the medical necessity of care provided, and keep records on the results obtained at the different levels of utilization review.

Methuen welfare office

Four claims examiners processed manually about 2,300 claims each month at this office. The office has not developed any parameters--except for a limit on the number of physician visits--to identify possible overuse and does not maintain records of reviews by its claims examiners or of questionable claims referred to the Lawrence regional office for resolution. Utilization review consists of

--verifying recipients' eligibility by checking with a master file of eligible recipients,

--comparing charges with fee schedules and making adjustments if required,

--checking for duplicate claims and possible overuse by comparing current claims with data maintained in recipient and provider profiles,

--checking the number of physician visits per recipient (claims for more than two visits per recipient in a month are referred to the regional office for evaluation of possible overuse),

--reviews by the office director on a random-sampling basis of claims selected from provider profiles to identify possible overuse which may not have been detected during review by the claims examiners, and

--checking with files of paid medical bills submitted by medically needy recipients to verify that they had met their shares of cost before Medicaid bills were paid on their behalf.

The utilization review system at Methuen can be improved by

--developing norms of service to identify possible overuse and

--keeping records on the results obtained at the different levels of utilization review.

Templeton welfare office

One medical clerk processes about 200 claims manually each month at this office. The office has not developed parameters to identify possible overuse and does not maintain records of its reviews or of questionable claims referred to the Worcester regional office for resolution. All claims are reviewed by the Templeton welfare office director, a social worker, and the office medical clerk. Utilization review consists of

--verifying recipients' eligibility by checking with a master file of eligible recipients;

--comparing charges with fee schedules and making adjustments if required;

--checking for duplicate claims and possible overuse by comparing current claims with data maintained in recipient and provider profiles;

--checking the number of physician visits per recipient (if, in the opinion of the medical clerk, an "unusual number" of physician visits are made by one recipient in successive months, the case is referred to the regional office for review);

--reviewing all claims by the office director and by the social worker assigned responsibility for the recipient involved to determine whether, in their opinions (without established norms of service or other criteria), there is any indication of overuse;

--checking with files of paid medical bills submitted by medically needy recipients to verify that they had met their shares of cost before Medicaid bills were paid on their behalf;

--recording dental work in recipient profiles, by tooth number, to analyze future claims; and

--maintaining for each recipient a record of prescription drugs to monitor the proper and economical use of prescription drugs.

The medical clerk informed us that she referred questionable claims to the regional office for further review and resolution. Without established criteria, she uses her own judgment as to what is questionable. For example, a dentist submitted a claim for cleaning teeth and a fluoride treatment for an 82-year-old Medicaid recipient. The medical clerk questioned the value of a fluoride treatment in this case and referred the claim to the regional office. Subsequently the regional office informed the medical clerk that the fluoride treatment may be performed annually but

only on persons under 21. Accordingly the claim for the fluoride treatment was disapproved.

The utilization review system at Templeton can be improved by

--developing norms of service to identify possible overuse and

--keeping records on the results obtained at the different levels of utilization review.

REGIONAL OFFICES

The Department of Public Welfare established a review system at each of the seven regional offices to supplement and extend the utilization review activities of the local welfare service offices. We visited the regional offices in Boston, Lawrence, and Worcester to evaluate utilization reviews. The nature and scope of such reviews were similar at the three regional offices.

A medical assistance program advisor and a staff of consultants evaluate and resolve questionable claims and problem cases submitted by the welfare service offices in each region. They meet with providers for direct consultations when they are not able to resolve questionable claims from available documentation. Claims which cannot be resolved by the regional offices are forwarded to the central office for resolution. The regional offices do not maintain records of the reviews of these claims. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in the claims were not available.

Medical assistance program advisors at the regional offices stated that, when overuse of a particular medical service is noted during their review of questionable claims, the regional staffs concentrate on reviewing that item of service or the provider involved. This is done by requesting the welfare offices to submit all or a sample of claims during a particular period for a provider or for an item of medical care or service.

The consultants also evaluate requests for medical care requiring prior approval and determine appropriate fees for bills submitted by local offices and pertaining to claims for services for which no fees have been established.

Late in 1969 the Department of Public Welfare started using dental consultants in the regional offices to approve or disapprove selected items of dental care before the service was provided. Of the 93 dental procedures listed in the department's fee schedule

--31, including bridgework and orthodontic X-rays, require prior approval;

--eight, including dental surgery and postoperative followup, require evaluation by a consultant to determine a reasonable fee before payment; and

--three, including interceptive orthodontics, require both prior approval and the determination of a fee.

Therefore 42 of the 93 dental procedures listed require prior approval, the determination of a fee before payment, or both.

Department of Public Welfare officials believed utilization review of dental services to be the most successful review. On the basis of reports submitted by the regional dental consultants, a department official estimated that, as a result of reviews made by the regional dental consultants, savings of $1,726,000 were realized in calendar year 1970.

Until the Department of Public Welfare has developed an effective State-wide computerized utilization review system, the regional offices should assist their local welfare offices in developing norms of service for use in identifying possible overuse. In addition, the regional offices should maintain records of reviews by its medical consultants so that statistics on claims reviewed and approved or disapproved and amounts of reductions in claims are available to analyze use of medical care or services.

CENTRAL OFFICE

At the central office the Department of Public Welfare has part-time consultants in dentistry, medicine, optometry, and podiatry and full-time specialists in dentistry, medicine, pharmacy, and surgery.

These specialists review and take final action on claims which could not be resolved at local welfare offices or regional offices, including claims which were for services requiring prior approval or fee determination and claims involving questionable use of services. When overuse of a particular medical service is noted during the review of questionable claims, the central office staff makes studies of claims pertaining to the item of service and/or the provider involved.

We discussed the review of claims pertaining to pharmacy services and podiatric services with the responsible central office staff.

Pharmacy program

Until June 1971 the department had a part-time pharmacist who reviewed claims submitted by regional offices and visited pharmacies and nursing homes to review their handling of Medicaid prescriptions. The Department hired a full-time Assistant Director of Pharmacy in June 1971 and two full-time pharmacists in September 1971. They resolve questions pertaining to pharmacy bills forwarded by the regional offices and conduct utilization reviews of pharmacy claims.

This group does not maintain records to show the results of its review of questionable claims submitted by the regional offices. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in the claims were not available. Examples of the utilization review activities conducted by this group follow.

Example 1

A regional office medical assistance program advisor noted that a pharmacy may have been billing the department for an excessive amount of prescription refills for nursing home recipients. A review was made of the pharmacy and nursing home prescription records and the staff found that the pharmacy was dispensing medication in 30-dose lots for nursing home recipients without regard to the doctors' written orders. As a result, the department is seeking a $4,380 refund from the pharmacy.

Example 2

The pharmacy staff also reviewed all bills submitted by another pharmacy during a 3-month period. This pharmacy was selected by the staff because of its high average prescription price. The review showed that

--overpricing was present in over 85 percent of the prescriptions;

--no prescription orders existed in some cases; in others only copies and telephone orders were on file;

--contrary to State requirements, prescriptions were refilled after 90 days from the date of issuance of the original prescriptions; and

--noncovered items were supplied.

On the basis of the results of its review, the pharmacy staff disallowed $1,899, or about 81 percent of the $2,336 that this pharmacy had billed the department during the 3-month period.

Podiatric program

The part-time consultant in podiatry receives for review and action several hundred claims each week which were questioned by local welfare offices and could not be resolved by the regional offices. The podiatrist consultant does not maintain records of these reviews. Statistics on claims reviewed and approved, or disapproved, and amounts of reductions in the claims were not available.

However, the podiatrist consultant informed us that he recalled having discussed with seven podiatrists their Medicaid claims which had been referred to him for review. He stated that the claims indicated an excessive number of treatments and estimated that about 75 percent of the claims were disallowed after his discussions with the podiatrists.

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In our opinion, redirecting central office utilization review activities toward the development and implementation of a State-wide utilization review system is necessary to provide the State with an effective way to control the quality, economy, and timeliness of Medicaid care or service.

REVIEWS BY HEW AUDIT AGENCY

In a June 1969 report on the Massachusetts Medicaid program, the HEW Audit Agency pointed out the need to develop and implement State-wide controls over provider claims

to avoid duplicate payments and payments that were excessive or that were for services to ineligible persons. The HEW Audit Agency found that the department had not provided welfare offices with detailed instructions on how provider claims should be reviewed to detect improper use of medical services. We found the same situation in our review.

In an April 1972 report, the HEW Audit Agency stated that the Department of Public Welfare had not effectively implemented a provider payment system to provide adequate control over claims for pharmaceutical services and that, as a result, the department was not in a position to determine that pharmaceutical claims were correctly priced or were in compliance with applicable regulations. In addition, the Audit Agency stated that the department had not established utilization review procedures for evaluating the quantity and quality of pharmaceutical services provided to Medicaid recipients. We also noted these conditions during our review.

The Department of Public Welfare issued new rules and regulations governing the Massachusetts Medicaid drug program; the changes became effective February 1, 1972, and will, if properly implemented, strengthen utilization review activities for drugs.

REVIEW BY DEPARTMENT OF THE STATE AUDITOR

An April 1972 report on a review of Massachusetts Medicaid drug billings by the Department of the State Auditor described numerous deficiencies in the drug program. The report resulted from a continuing audit of offices of the Department of Public Welfare initiated in 1971. The audit included a survey of pharmacies throughout the State and related billings to local welfare offices. Two examples follow.

Example 1

From July 18, 1968, through December 13, 1971, a recipient received drugs valued at $2,303 and, of this, $2,229 was for one habit-forming drug and the needles and syringes used to administer it. Four pharmacies dispensed

this drug to the recipient. Prescriptions for this recipient at one pharmacy showed that

--one prescription called for three refills but was refilled 46 times;

--one prescription, which was not signed by a physician, did not authorize any refills but was refilled 49 times; and

--another prescription, which was not signed by a physician, did not authorize any refills but was refilled 55 times.

Example 2

Another recipient used the services of at least four physicians in a 1-month period to obtain excessive quantities of a narcotic item and used several pharmacies to get these prescriptions filled. Further analysis showed that one welfare office paid for 734 tablets for this recipient from January through October 1971.

After the State Auditor's examination, this recipient was arrested and charged with 35 counts of failing to disclose to a physician a narcotic drug treatment from another physician and 35 counts of making false representation to obtain narcotics.

EVALUATION OF CONTROLS OVER NONINSTITUTIONAL SERVICES

The Department of Public Welfare has not established effective utilization controls for noninstitutional services. For the most part, the department relies on its local and regional offices to control Medicaid expenditures. The department has not provided the local welfare offices with instructions describing procedures to be followed in reviewing provider claims to detect ineligible participants, duplicate payments, excessive fees, overuse, and noncovered services. Therefore utilization review activities are carried out with varying degrees of expertise at the 155 welfare offices.

Each of the four welfare offices which we reviewed employed different criteria to determine which Medicaid claims should be evaluated for possible overuse. There were no records showing (1) the results of reviews made by the welfare offices, (2) the number of claims referred to the regional offices, or (3) the results of reviews made by the regional offices. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in the claims were not available. Central office officials informed us that, to their knowledge, none of the other 151 welfare offices kept records of claims reviewed.

Although the volume of Medicaid claims received by the State is too large for effective manual processing, computers have not been obtained and used to summarize claims data, to develop participant histories of services provided or received, and to screen and identify participants deviating from normal program use.

Reviews by the HEW Audit Agency and the State Auditor have pointed out numerous weaknesses in the State's control of payments for noninstitutional services.

New rules and regulations developed for the Massachusetts Medicaid drug program will, if properly implemented, strengthen reviews for drugs. Overall, however, the department has not established effective review controls for noninstitutional services.

CHAPTER 5

ADEQUACY OF RESOURCES FOR UTILIZATION REVIEW

Because of the way in which the review function is organized and operated in Massachusetts, it is difficult to judge the adequacy of the aggregate resources applied to this function. The State has recognized the need for more effective controls over all public assistance expenditures, including those for Medicaid, and has developed a plan for an automated payment and control system.

PROPOSED AUTOMATED SYSTEM

In recognition of the inadequacy of its present resources to properly manage public assistance programs--including Medicaid--spending hundreds of millions of dollars a year, the Department of Public Welfare developed a plan to obtain additional resources, including a computer system, to provide more effective controls over payments. The department estimated that it would take 2 years to implement the plan. The estimated development cost was $7 million, half of which the Federal Government would pay. The estimated annual operating cost was $3.9 million.

The plan for implementing the system was in a report from the department to the Secretary of HEW in December 1971. The report identifies the department's major problem as inadequate control over its financial operations and describes a financial management control system which will use computers and is to include the following features:

1. A recipient payment control system which automatically checks recipient eligibility and amount of grant, calculates and writes the check, and keeps accounts of benefits delivered.

2. A vendor payment control system which automatically checks recipient eligibility, vendor qualifications, and fee charged and writes the check and accounts for disbursements by recipient, vendor, and accounting classification.

3. An accounting and reporting capability which automatically balances and reconciles accounts and reports management information.

4. A finance unit in each of the seven regional offices to collect and prepare financial data and distribute payments and reports.

5. A central computerized recipient master file.

6. A central backup capability to insure continuing operations if for any reason a regional operation fails.

The plan, as described above, will improve some of the conditions discussed in this report. It does not, however, provide for (1) computer equipment to develop participant histories of services provided or received and to screen and identify participants deviating by specified margins from prescribed parameters, (2) review and investigation of deviants to determine whether medical care or services are appropriate or whether overuse has occurred, and (3) appropriate corrective measures in cases involving overuse.

In July 1972 we were informed that the Department of Public Welfare had begun to implement the proposed plan. Until it can be fully implemented, the department plans to select a 5-percent sample of Medicaid claims for review. Department officials estimated that this interim procedure would require additional staffing at the central office and the regional offices, as follows:

Central office

Present staffing	Additional staff needed
1 assistant commissioner for medical assistance	1 assistant director of medical assistance
1 director of medical care	1 senior accountant
1 assistant director, pharmacy program	1 stenographer
2 pharmacists	1 administrative assistant
1 medical advisor	1 senior clerk
1 dental advisor	
1 surgical advisor	
2 part-time dental consultants	
2 part-time medical consultants	

Regional offices

Present staffing	Additional staff needed
7 medical assistance program advisors	7 associate regional administrators
7 dental consultants	6 medical assistance program advisors
7 medical consultants	6 pharmacists
6 surgical consultants	7 administrative assistants
	14 medical social workers
	7 head clerks
	7 senior statistical clerks
	14 senior clerk stenographers
	21 junior clerk typists

An allowance for the additional staff needed was included in the department's fiscal year 1973 budget.

Although utilization review activities could be improved if the additional personnel requested are obtained, we believe that a computerized utilization review system is essential for effective utilization review of the Massachusetts Medicaid program.

CHAPTER 6

EXTENT OF ASSISTANCE GIVEN BY HEW

The Medical Services Administration in the Social and Rehabilitation Service's regional office in Boston assists the six New England States in administering their Medicaid program. Service officials advised us that, because of the small size of the staff (five professional employees), the amount of assistance provided to develop adequate utilization review systems in these States has been very limited.

Service officials said that the regional office concentrated on getting Massachusetts to develop a good management system for administering the public assistance and Medicaid programs. This approach was taken because the Department of Public Welfare has had problems in administering the entire welfare program, not just the Medicaid program and the utilization review system.

The Service suggested that the department hire a management consulting firm to develop an improved financial management system, and the State contracted with two consulting firms. One issued a report in April 1969 and the other in March 1971. Service officials stated that both consultant firms failed to develop an effective financial management system.

According to Service officials, the regional office then tried to get the department to

--implement a State-wide numbering system for welfare and Medicaid recipients so that the payment system could be centralized and automated and

--contract with a third-party intermediary to process all drug bills received by the department.

A Service official estimated that, if the processing of drug bills were contracted out to an intermediary, about 40 percent of the department's paperwork could be eliminated. At the completion of our fieldwork in November 1971, none of these suggestions had been accepted.

The Service official also stated that, until the State institutes some type of a centralized/automated system for processing public assistance and Medicaid claims, an effective utilization review system cannot be achieved.

In October 1971 the Service provided Massachusetts with a model Medicaid Management Information System. The model system--the use of which is optional--is a result of HEW efforts to assist the States in improving the methods they use to administer their Medicaid programs and to correct certain problem areas existing in some States.

The objectives of the model system are to provide for the effective processing, control, and payment of claims and to provide State management with necessary information for planning and controlling their Medicaid programs.

The model system provides a broad "how to do it" framework within which States can develop detailed system specifications to meet requirements peculiar to their own systems. Within the model system, descriptions of six separate subsystems define and outline the methods to be used for claims processing and payment, management and administrative reporting, and surveillance and utilization review.

The surveillance and utilization review subsystem is designed to detect misuse of the Medicaid program by providers and recipients. The system provides for (1) the use of computer equipment to summarize claims data, to develop participant histories of services provided or received, and to screen and identify participants deviating by specified margins from prescribed parameters, (2) the review and investigation of deviants to determine whether medical care or services are appropriate or whether misuse has occurred, and (3) appropriate corrective measures in cases involving misuse.

To test the adaptability of the model system to the specific needs of State Medicaid programs, HEW is implementing the system in Ohio. The general design of the model system is being tailored to meet Ohio's specific needs. HEW officials informed us that the system would be operational by about October 1, 1972.

A Department of Public Welfare official said that:

--The HEW model system was excellent and could be adapted to the Massachusetts Medicaid program.

--Massachusetts had requested all the information needed to implement the system on the basis of its implementation in Ohio.

--However, before his department could adopt the HEW model system, the State administration and legislature would have to accept it.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Massachusetts has not developed a State-directed, computerized system to control Medicaid expenditures. The effective administration of the large volume of Medicaid services provided by the State requires such a system. Although the present Massachusetts system is producing some positive results, the system does not provide for the systematic accumulation of data required by management officials to efficiently administer utilization review activities.

The Department of Public Welfare has not established general controls applicable to all services to insure that (1) recipients and providers are eligible to participate in the program and (2) providers are neither paid twice for the same care or service nor paid in amounts exceeding fee schedules or other applicable limits.

Massachusetts made some progress during calendar year 1971 in strengthening utilization reviews of its Medicaid institutional services. The State revised and improved its regulations for institutional services but deferred application of the revised regulations to intermediate care facilities until 1975. Because intermediate care became a Medicaid service on January 1, 1972, it should now be subject to the State's utilization review requirements.

Massachusetts officials stated that its institutional reviews had primarily emphasized assisting the participating institutions to develop adequate utilization review plans. However, at the time of our review in November 1971, these plans had been approved for only 29 percent of the participating hospitals and skilled nursing homes.

The institutional services review requirements of the Social Security amendments of 1967 became effective in April 1968. The State's progress toward meeting these requirements has been slow.

The Department of Public Welfare has not established effective utilization controls for noninstitutional services.

Although the department relies on its local and regional offices to control Medicaid expenditures, it has not provided these offices with adequate instructions describing procedures to be followed in reviewing provider claims to detect ineligible participants, duplicate payments, excessive fees, overuse, and noncovered services. Therefore the degree to which the utilization reviews are effective varies widely among 155 welfare offices.

The department does not keep records of reviews of claims questioned by the local welfare offices and referred to a regional office and/or the central office for resolution. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in claims were not available.

The effective administration of the large volume of Medicaid services provided by the State requires a centralized computerized management system. Because of the way in which the review function is organized and operated in Massachusetts, it is difficult to judge the adequacy of the aggregate resources applied to this function. The State has recognized the need for more effective controls over all public assistance expenditures, including those for Medicaid, and has developed a plan for an automated payment and control system. The system, which is now being implemented by the State, will improve some of the conditions discussed in this report; however, it will not provide for an effective utilization review system.

The small size of HEW's regional professional staff has limited the amount of assistance provided the State in developing an adequate utilization review system. However, HEW provided substantive assistance to the State in October 1971 when it provided Massachusetts with the model Medicaid management information system. The State has requested information needed for the implementation of the HEW model system in Massachusetts. We believe that HEW's model system offers Massachusetts opportunities for improving its utilization review system and should be studied thoroughly.

RECOMMENDATIONS TO THE SECRETARY OF HEW

State officials have recognized the need for improvement in their Medicaid utilization review system. Their efforts, which have resulted in some improvement, have been directed toward alleviating problems in segments of the system; what is needed, however, is the effective development of an entire system. We recommend that the Administrator of the Social and Rehabilitation Service, HEW, be required to assist the State and to monitor State actions to

--thoroughly study the HEW model system for the purpose of adopting design features offering opportunity for establishing an effective utilization review system,

--provide for the systematic accumulation of data required by management officials to efficiently administer utilization review activities,

--apply its utilization review regulations to intermediate care facilities,

--provide for central State administration of the Medicaid utilization review system, and

--assist participating hospitals and skilled nursing homes to develop adequate utilization review plans.

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

July 2, 1971

The Honorable Elmer B. Staats
Comptroller General of the
United States
Washington, D. C. 20548

My dear Mr. Staats:

In accordance with the Social Security Amendments of 1967, State plans for medical assistance (Medicaid) must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization and to assure that payments are not in excess of reasonable charges.

A number of States which have adopted Medicaid programs have contracted with fiscal agents to perform utilization review functions as prescribed by section 1902(a)(30) of the Act. Nearly half of the States, however, do not use a fiscal agent in their program and some States--although they use fiscal agents to carry out some Medicaid functions--have retained responsibility for utilization review. We are aware that you are currently reviewing the activities of certain programs which involve fiscal agents.

I would appreciate it if the General Accounting Office would conduct an examination in the States of Florida, Maryland Massachusetts and Missouri, which do not use fiscal agents for utilization review purposes and report to the Committee concernir the functioning of the utilization review systems in those States.

During your examination, I would suggest you inquire into such matters as:

1. Results being achieved under the utilization review systems.

2. Whether the selected States appear to have the necessary resources to carry out their utilization review program.

3. Whether instances of apparent excessive use of medical services are appropriately followed up and corrective action instituted.

4. The extent of assistance given by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare to the States in the development of utilization review systems.

Any questions that may arise during the examination may be discussed with the Committee staff members.

Sincerely yours,

Wilbur D. Mills
Chairman

WDM/ff

U.S. GAO, Wash., D.C.